


Patient Name: _____ Address: _____

City: _____ State:  ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ (years) _____ (months) Sex:  ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Mother: _____ Age: _____ Father: _____ Age: _____

Highest grade in school: _____ Occupation: _____ Highest grade in school: _____ Occupation: _____



Check one: ☐ Biological Parent ☐ Adoptive Parent Check one: ☐ Biological Parent ☐ Adoptive Parent

Past and Present Health: _____ Past and Present Health: _____

SIBLING NAME	AGE	RELATIONSHIP TO PATIENT	PAST AND PRESENT HEALTH	GRADE IN SCHOOL

Referring Physician or Agency: _____ Primary Care Physician or Pediatrician: _____

Address: _____ Address: _____

City: _____ State:  ZIP: _____ City: _____ State:  ZIP: _____

Phone Number: _____ Phone Number: _____

Please write a brief account of the child's illness or complaint, beginning with the initial complaint, the age at the time it began, a description of the complaint, and the course of the complaint.

Please **LIST ALL MEDICATIONS** the child has has taken in the *past*. (Attach a separate list if necessary or bring list with you to the appointment)

MEDICATION	DOSE/FREQUENCY	YEARS/MONTHS TAKEN	HOW DID THIS EFFECT THE COURSE OF THE COMPLAINT?

PREVIOUS TESTING (Please list any diagnostic tests done. We would like to see the **CD's** from all of these tests)

Test	When	Where	Results

FAMILY MEDICAL HISTORY (Please indicate below if any immediate family members have the illness. List the family members and their age at onset of condition)

<input type="radio"/> ADHD		<input type="radio"/> Cerebral Palsy		<input type="radio"/> Learning or reading difficulties	
<input type="radio"/> Alcoholism		<input type="radio"/> Chiari malformation		<input type="radio"/> Mental retardation	
<input type="radio"/> Aneurysm		<input type="radio"/> Chromosome abnormality		<input type="radio"/> Muscle or nerve disease	
<input type="radio"/> Asthma		<input type="radio"/> Convulsions, Epilepsy, Seizures		<input type="radio"/> Stroke	
<input type="radio"/> Autism		<input type="radio"/> Depression/Anxiety		<input type="radio"/> Thyroid disease	
<input type="radio"/> Bipolar or Schizophrenia		<input type="radio"/> Diabetes		<input type="radio"/> Tics	
<input type="radio"/> Bleeding disorder		<input type="radio"/> Gait abnormality		<input type="radio"/> Tourette Syndrome	
<input type="radio"/> Brain Tumor		<input type="radio"/> Headaches/Migraines		<input type="radio"/> Tremors	
<input type="radio"/> Cancer (type)		<input type="radio"/> High blood pressure		<input type="radio"/> Tuberculosis	

PREGNANCY AND BIRTH HISTORY: Were there any serious problems with the pregnancy or birth of your child?

If yes, please complete below. If no, please skip ahead to **developmental landmarks of child**.

☐ NO ☐ YES

Duration of pregnancy: _____ (months) Tobacco, alcohol, or illicit drug use during pregnancy? ☐ NO ☐ YES Which? _____

Was labor: ☐ Spontaneous ☐ Induced ☐ Forceps ☐ C-section **Born:** ☐ Head first ☐ Feet first

Difficulties (please explain): _____

Birth weight: _____ lbs. _____ oz. OR _____ kg. Did the baby have any trouble starting to breathe? ☐ NO ☐ YES

Did the baby have any trouble while in the hospital? ☐ NO ☐ YES

If yes, please describe: _____

Age of baby at time of hospital discharge: _____ Was the child adopted? ☐ NO ☐ YES

DEVELOPMENTAL LANDMARKS OF CHILD (Please list dates): Were the developmental milestones normal? ☐ NO ☐ YES

If no, please complete below (list dates next to each development landmark). If yes, please skip ahead to **school progress**.

Smiled:		Went from laying to sitting on own:		Spoke single words:	
Made Random Sounds:		Said repetitive syllables (ma-ma, da-da):		Spoke short sentences:	
First sat alone when placed:		Walked alone:		Potty trained:	
Able to ride a tricycle:		Able to ride a bicycle:			

SCHOOL PROGRESS (if child is not in school, skip ahead to *illnesses*):

Grade in school: _____ Name of school or pre-school: _____

Best subject in school: _____ Worst subject in school: _____

Does the child do well in school? ☐ NO ☐ YES Any learning or reading problems? ☐ NO ☐ YES

Were any grades repeated? ☐ NO ☐ YES

ILLNESSES (Please select if the patient has any of the following):

<input type="radio"/> Chicken Pox	<input type="radio"/> Encephalitis	<input type="radio"/> Measles	<input type="radio"/> Meningitis	<input type="radio"/> Mumps	<input type="radio"/> Polio	<input type="radio"/> Removal of tonsils
<input type="radio"/> Rheumatic Fever	<input type="radio"/> Roseola	<input type="radio"/> Scarlet Fever	<input type="radio"/> Serious head trauma	<input type="radio"/> Tuberculosis	<input type="radio"/> Whooping Cough	Other: _____

REVIEW OF SYSTEMS (Please indicate if the child has had any of the following symptoms):

GENERAL:

- ☐ Weight loss
- ☐ Decreased appetite
- ☐ Fever
- ☐ Chills
- ☐ Sleep disturbance

NEURO:

- ☐ Headache, recurrent
- ☐ Fainting (Syncope)
- ☐ Seizure
- ☐ Weakness, clumsiness

EYES:

- ☐ Eye pain
- ☐ Trouble with vision

EARS:

- ☐ Ear pain
- ☐ Hearing loss

SKIN:

- ☐ Rash
- ☐ Eczema

RESPIRATORY:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing or asthma

GENITO-URINARY:

- ☐ Trouble with urination
- ☐ Bladder or kidney problem

GASTRO-INTESTINAL:

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain

MUSCULOSKELETAL:

- ☐ Back pain
- ☐ Joint pain

PSYCH:

- ☐ Depression
- ☐ Anxiety

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Palpitations

HEMATOLOGY:

- ☐ Easily bruising
- ☐ Abnormal bleeding

ALLERGY:

- ☐ Allergy to medication
- ☐ Reaction to medication

PRESENT TREATMENT: please list all medications the child is currently taking.

MEDICATION	DOSE/FREQUENCY	YEARS/MONTHS TAKEN	REASON PRESCRIBED

Allergies to medications? ☐ NO ☐ YES If yes, please list medications and reaction below:

Other physicians or health care workers seen by patient and reasons:

HOSPITALIZATIONS:

When	Where	Why

☐ NO ☐ YES

IMMUNIZATION	YES/NO	DATE COMPLETED
DPT (diphtheria, tetanus, whooping cough)		
Three doses of polio vaccine		
MMR (Measles vaccine)		
Abnormal Skin test for tuberculosis		
Other immunizations, please list		

Does your child get along well with other children?

Who does your child live with?

[illegible]

This history form was completed by: (Printed Name) _____ Date: _____

Signature: _____